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Note by the Secretary-General

The Secretary-General hereby transmits a report prepared by the Director-General of the World Health Organization on the interlinkages between health and the environment and health and natural disasters, pursuant to General Assembly resolution 66/115.

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Report of the Director-General of the World Health Organization on global health and foreign policy

Summary

The present report is submitted in response to General Assembly resolution 66/115 on the interlinkages between health and the environment and health and natural disasters. It elaborates on the challenges inherent in those issues and provides examples of actions at the national and international levels. The ongoing work to strengthen national capacity to cope with those challenges is highlighted, as are the mechanisms and inter-agency structures within the United Nations system.

On the basis of consultations with Member States, universal health coverage is examined, including approaches to supporting and strengthening health systems, in particular in response to the challenges posed by climate change and natural disasters. In the past two years, a number of high-level meetings have stressed the importance of universal health coverage in sustaining health gains, building resilient societies and protecting individuals from impoverishment when they are sick. Access to the services that are needed improves health outcomes, allowing people to earn and children to learn, thus providing them with a means to escape poverty. At the same time, financial risk protection prevents people from being pushed back into poverty. Those two building blocks of universal health coverage are critical to sustainable development and poverty reduction.

In June 2012, the participants in the United Nations Conference on Sustainable Development put the challenges of sustainable development, encompassing its three pillars — economic, social and environmental — high on the international development agenda. Ways to address development challenges beyond the Millennium Development Goals were examined, and health was recognized as an intrinsic element of any such development.

I. Introduction

1. In adopting resolution 66/115 on global health and foreign policy, the General Assembly continued to recognize the close relationship between global health and foreign policy and the need for further efforts to create a global policy environment supportive of global health. The Assembly welcomed a number of health-related high-level meetings held in 2011 and their political outcomes. These included the Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS (resolution 65/277, annex), the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (resolution 66/2) and the Rio Political Declaration on Social Determinants of Health of 2011.

2. In resolution 66/115, the General Assembly also considered two areas of interdependence: health and the environment and health and natural disasters. The Assembly requested the Secretary-General, in close collaboration with the Director-General of the World Health Organization (WHO), with the participation of relevant entities of the United Nations system and in consultation with Member States, to submit a report to the Assembly at its sixty-seventh session that would reflect the interlinkages between health, the environment and natural disasters.

3. In June 2012, the United Nations Conference on Sustainable Development, held in Rio de Janeiro, Brazil, adopted an outcome document entitled "The future we want", which was subsequently adopted by the General Assembly as resolution 66/288 (annex). In the outcome document, the role that health can play at the heart of sustainable development policies was recognized as a precondition for, or an outcome and indicator of, all three dimensions of sustainable development.

4. All of these political documents underpin the growing relevance of health in the formulation of the global political and developmental agenda, warranting attention at the highest political level. Health is recognized as a strategic element for the achievement of the internationally agreed development goals, including the Millennium Development Goals, and as central to sustainable development, linking its environmental, social and economic pillars.

5. The links between better health, the economy, environmental sustainability and social progress are well established: people who are healthy are better able to learn, to earn and to contribute positively to the societies in which they live. A changing climate in the longer term threatens the fundamental requirements for health — clean air, safe drinking water, a secure food supply and adequate nutrition and shelter. In addition, it increases the frequency and intensity of natural disasters. Conversely, a healthy environment is a prerequisite for good health. Reduction of air, water and chemical pollution risks can prevent up to a quarter of the total burden of disease and a significant proportion of childhood deaths.

6. Persistent poverty levels, exacerbated by new and emerging trends in population growth, ageing, migration, urbanization and climate change, put new strains on health systems. Equitable benefits have not been reached through solely economic means, and gaps between and within countries require focused and joint efforts to address inequalities and their consequences for health. Political commitment is essential in order to reach the most vulnerable populations.

7. Strong, well-designed health delivery systems, based on universal health coverage, not only protect individuals from illness, but also contribute to the resilience of societies by protecting people from impoverishment when they are sick. They can further the empowerment of women and represent a means by which people can hold national authorities accountable.

8. Improvements in human health contribute to the achievement of sustainable development. While there have been major advances in human health over the past two decades, the benefits have not been equally shared. Despite a growing recognition that progress in health depends on trade, intellectual property, agriculture, transport, employment and many other aspects of international and domestic policy, coherence across sectors remains elusive. A multisectoral approach is needed not only to sustain development gains and maintain progress in the fight against major diseases, but also to equip health systems to respond adequately to these new challenges.

9. In too many societies people remain vulnerable to sudden crises. Financial uncertainty and environmental factors exacerbate these risks, as they have a severe impact on the most disadvantaged populations. Supporting people and communities in becoming more resilient requires concerted efforts to ensure access to basic services and provide financial protection. These are the two main elements of universal health coverage.

10. A consultative process was carried out with Member States in which WHO was encouraged to address all of these elements in the present report.

II. Health and the environment

A. Key hazards and impacts

11. About one quarter of the global burden of disease is attributable to environmental risks. There is now strong evidence that anthropogenic climate change is influencing the environmental determinants of health. Climate change, with the resulting extreme weather incidents, is likely to lead to increased air pollution patterns and an increase in water-, food- and vector-borne diseases. Estimates produced by the secretariat of the United Nations Framework Convention on Climate Change, the World Bank and WHO indicate that climate change could add at least $2 billion to $12 billion to annual health costs in developing countries by 2020.

12. Those impacts are concentrated on the poorest populations and affect some of the largest disease burdens, including malnutrition, diarrhoea and vector-borne diseases such as malaria. Together they kill over 5 million people each year. The burden is significantly higher for children in developing countries. They face severe health risks from unsafe drinking water and sanitation (responsible for most childhood deaths from diarrhoea) and household air pollution (approximately half the childhood cases of pneumonia are due to indoor smoke from inefficient cook stoves reliant upon wood, biomass and coal).

13. The societal changes and transnational population movements of so-called "environment" migrants due to climate change are significant and they will present additional health challenges in both countries of origin and host countries.

14. Unsustainable development is exacerbating many traditional environmental health risks and contributing to the emergence of new risks in the natural and built environment, leading to a double burden particularly for the poor. These include the following:

(a) *Natural environments.* Climate change leads to an increased frequency of extreme weather and related disasters (see sect. III below) and drought, having an impact on food production and thereby leading to undernutrition and malnutrition. Loss of forests, desertification, loss of biodiversity and degradation of water resources are also altering patterns of vector-borne or infectious disease transmission, as well as depleting important sources of food, fuel, shelter, medicinal plants and other ecosystem services essential to health;

(b) *Built environments.* Unsustainable urban development, particularly in slums, is a key contributor to urban air pollution, traffic injury, unsafe and unhealthy housing and lack of physical activity related to poor urban planning. These are all factors in the observable rise in the frequency of non-communicable diseases (e.g. cardiovascular and respiratory diseases and obesity-related diabetes). While access to clean drinking water has improved considerably in the past decade, lack of access to clean, sustainable energy is a critical factor in household air pollution in both urban and rural areas. Lack of household access to sanitation and poorly managed waste from both domestic and agricultural sources (e.g. livestock production) create sanitation hazards that are potential sources of disease outbreaks.

15. Social determinants of exposure to environmental hazards play a significant role in designing the response systems. In virtually all cases, the health of people in developing countries, and particularly of those who are poor, is most at risk from environmental hazards related to climate change and unsustainable development. For instance, in the case of drought related to climate change, smallholders who eke out a subsistence living from the land will be most at risk of food insecurity and undernutrition.

16. In urban areas, poor neighbourhoods tend to be the most affected by flooding and mudslides due to extreme weather, unsafe drinking water and sanitation and lack of clean, efficient household energy sources. In addition, it is the poor and vulnerable groups (e.g. children) in developing countries who often live in urban areas in and around industry and major traffic arteries, exacerbating chronic respiratory health issues. The same socioeconomic groups are most at risk from traffic injury owing to a lack of safe, affordable, efficient rapid transit and walking or cycling networks to essential destinations. Similarly, the urban poor often lack access to affordable fresh fruits and vegetables, which are essential to a balanced diet that can help prevent obesity, diabetes and other non-communicable diseases. Finally, the poor are most at risk from multiple chemical, air-quality and ergonomic environmental hazards in the workplace. These are particularly acute in the informal sector, where many of the world's poor are employed.

17. Many of the most acute environmental health risks to vulnerable groups can be substantially reduced through development policies that are more climate-friendly and sustainable, particularly for transport, housing, agriculture and energy. These need to be coupled with better governance mechanisms for implementing policies in the urban and rural sectors, as well as in occupational settings. Health gains, and particularly equitable distribution of health gains, from development, are not automatic, however. Policies need to be evaluated by a "health lens" in terms of their health impacts and indicators that are relevant to health, to measure progress against goals.

B. International frameworks for action

18. A number of international conventions and agreements provide recognized frameworks, both binding and non-binding, for more concerted action on linked health, environment and development issues. These include:

(a) The three Rio conventions: the United Nations Framework Convention on Climate Change, the Convention on Biological Diversity, and the United Nations Convention to Combat Desertification in Those Countries Experiencing Serious Drought and/or Desertification, Particularly in Africa. For example, in meeting the climate change mitigation commitments of the Framework Convention on Climate Change, improving access to clean public transport and to safe physical activity could greatly reduce CO_2 emissions, along with substantially reducing an estimated 1.3 million global deaths from outdoor air pollution, 1.3 million annual deaths from traffic accidents and 3.2 million deaths from physical inactivity. Providing the poorest communities with access to cleaner domestic energy technologies could reduce the nearly 2 million annual deaths from indoor air pollution. Reduced reliance on diesel fuels for transport and on rudimentary biomass stoves would not only help cut respiratory disease and cancers, but also lead to a rapid, significant reduction in emissions of certain short-lived climate change pollutants, such as black carbon, buying time for the world to tackle longer-lived carbon dioxide. Strengthened public health programmes to manage environmental health risks, improve disease surveillance and response and health action in emergencies, are critical contributions to the adaptation objectives of the Convention;

(b) Multilateral environment agreements. The Stockholm Convention on Persistent Organic Pollutants, the Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal and the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade, provide frameworks for the promotion of safer chemicals and chemicals waste management, including agricultural, industrial and health-care chemicals and waste (health-care waste in and of itself has considerable environmental health impacts). The United Nations Environment Programme and WHO have a long-standing programme of cooperation to advance the implementation of those conventions;

(c) Millennium Development Goals. Millennium Development Goal 7 on environmental sustainability relates to critical environmental health-related goals, such as improving access to clean drinking water and improved sanitation;

(d) World Health Assembly resolutions. A number of resolutions adopted by the World Health Assembly have strengthened health sector involvement in foreign policy issues relevant to the environment and development and provide a framework for further future actions. Among these are resolutions WHA 60.26 on a global plan of action for workers' health, WHA 61.19 calling for more assertive health sector actions to reduce health threats from climate change and WHA 64.24, which provided for strengthened involvement of the health sector in international water-related policies, and a report of the WHO Executive Board on the United Nations Conference on Sustainable Development (EB 130/36);

(e) The foreign policy and global health initiative. This initiative identified health and the environment as one of its 10 priority areas. Under the leadership of a

core group of seven countries,[1] the General Assembly adopted resolution 66/115, in which it highlighted the relevant interlinkages between health and the environment. In the resolution, the Assembly called for more attention to be paid to health-related issues on the global environmental agenda and to environmental issues on the health agenda;

(f) Outcome document of the United Nations Conference on Sustainable Development, entitled "The future we want". From the beginning of the Rio process in 1992, the complex interaction between health and environment was recognized. The original Rio Declaration on Environment and Development of 1992 underlined the centrality of health and noted: "human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature". In the "The future we want", participants not only reaffirmed the centrality of health in its own right, but also stressed interlinkages as well as the health implications and health dimensions of sustainable cities, air quality, healthier transport, and environmental and human exposure to hazardous chemicals, and stressed the critical role of modern energy sources in improving health and well-being.

C. Strengthening the evidence base to inform country policies, norms and actions

19. Following the United Nations Conference on Sustainable Development, there is a clear need for better integration of health concerns into future development strategies, policies and programmes for poverty eradication and sustainable development, as well as the for the future development of development goals and/or sustainable development goals beyond 2015. To achieve that, close cooperation with the health sector is essential, not only with respect to universal health coverage, but also to ensure that development in other sectors optimizes health co-benefits.

Climate change mitigation and sustainable development

20. In the context of sustainable development and in the areas of housing, health sector facilities, transport, agriculture and household energy, health impacts should be considered in the formulation of climate change mitigation policies. Key findings in those areas and best practices need to be integrated into climate change policies and funding mechanisms. For example, improving health facilities' access to clean, renewable sources of energy could reduce emissions related to buildings as well as expanding access to health services in energy-poor developing countries. To date, few health facilities have had access to financing for building construction or retrofits to improve energy efficiency.

Climate change adaptation

21. Over 30 countries have completed "vulnerability and adaptation" assessments and 15 developing countries have implemented health adaptation programmes to strengthen preparedness for climate change (e.g. adaptation of water and sanitation services to extreme weather conditions) and improve national monitoring mechanisms.

[1] Brazil, France, Indonesia, Norway, Senegal, South Africa and Thailand.

Research on environmental risk factors

22. WHO is updating estimates on the burden of disease attributable to environmental risks in both the natural and built environments; these estimates also look at the distribution of risks among poor countries and vulnerable populations.

Strengthening of national monitoring mechanisms

23. A number of actions have been taken or are in preparation, including:

(a) Using publicly available national data, WHO has created up-to-date global databases on urban air pollution (covering over 1,100 cities), household energy (143 countries) and indoor air pollution measurement (250 communities);

(b) A new database on energy access in health facilities, covering 17 countries, mostly in sub-Saharan Africa but also including selected countries in Asia and the Americas, is about to be published. The data reflect an urgent need for more attention to be paid to energy capacity in health services as a means of expanding universal health-care access and coverage;

(c) Work is continuing to finalize guidelines for household energy aimed at providing developing countries with better guidance on choice of technologies and best practices that can reduce health risks and injuries from indoor air pollution;

(d) Guidelines are being developed for healthy housing in the context of sustainable development, similar guidelines on healthy and sustainable transport are planned;

(e) Partners within the United Nations system are working on designing and promoting tools for countries to use in integrated risk assessments and management of water and sanitation safety plans, health impact assessments of development projects, household energy choices and food safety.

III. Health and natural disasters

A. Impact of emergencies and disasters on human health and health systems

24. Natural disasters place enormous stress on societies and often have a significant impact on people's lives. Disasters may cause ill health directly or through the disruption of health systems, facilities and services, leaving many without access to health care in times of emergency. Basic infrastructure, such as water supplies and safe shelter, which are essential for health, can also be affected. Deaths, injuries, diseases, disabilities, psychosocial problems and other health effects can be avoided or reduced by emergency risk management measures involving health and other sectors.

25. Health inequities increase during times of crisis, requiring special efforts to meet the needs of the poorest and reach the most vulnerable populations. Ultimately, the disasters create barriers to progress on the health-related Millennium Development Goals, as they often set back hard-earned development gains.

26. There is an increasing emphasis in the health and emergency management sectors on promoting an "all-hazards" approach, as many actions to manage the

risks to health from natural hazards are common to biological (e.g. epidemic disease, infestations of pests), technological (e.g. chemical substances, radiological materials, transport crashes) and societal (e.g. conflict, stampedes, acts of terrorism) hazards.

27. Between 2000 and 2009, an average of some 270 million people annually were affected by natural and technological disasters.[2] More than 1.1 million deaths were recorded in large-scale natural disasters — some 4,130 events in all — in the past decade.[3] The incidence of natural disasters has been increasing, and climate change will increase the risk for millions of individuals, their homes, their communities and the infrastructure that supports them.

28. A comparative analysis of disaster statistics in Latin America found that for each disaster listed in global disaster databases, there are some 20 other disasters with a destructive impact on local communities that are not recorded.[4] In Latin America, the cumulative effect of 10 years of local disasters was found to have had a greater impact on the poor than any single event.[5]

29. Worldwide, the loss of life from disasters is far higher among developing countries than it is in developed countries. Unsustainable rural development and urbanization also place more of the world's population at risk. For example, in the past 30 years, the proportion of people living in flood-prone river basins has increased by 114 per cent and the proportion of people living on coastlines exposed to cyclones has grown by 192 per cent.[6] Over half of the world's large cities (with a population of from 2 to 15 million) are highly vulnerable to seismic activity.

30. The burden of disasters falls disproportionately on vulnerable populations, namely the poor, ethnic minorities, old people and people with disabilities. Various risk factors for human vulnerability to disaster-related morbidity and mortality include low income, low socioeconomic status, lack of home ownership, single-parent families, age older than 65 years or younger than 5 years, female sex, chronic illness, disability and social isolation or exclusion.[7] High-risk populations must be prioritized in targeted efforts to mitigate human vulnerability. As hazards affect different groups of people in different ways, reporting on the health indicators for emergency risk management programmes needs to be differentiated to take account of the variance in vulnerabilities, resilience and response capacities related to gender, socioeconomic factors, age, disability, mobility, social isolation and ethnicity.

31. In the context of emergency risk management, public health programmes build the capacities and resilience of individuals and communities to risks, reduce the

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[2] See the International Disaster Database (EM-DAT), Centre for Research on the Epidemiology of Disasters, Université Catholique de Louvain, Brussels, 2009, available from www.emdat.be.

[3] United Nations International Strategy for Disaster Reduction, "Towards a post-2015 framework for disaster risk reduction", 2012.

[4] World Bank, *World Development Report 2011: Conflict, Security and Development* (Washington, D.C., 2011).

[5] United Nations Children's Fund, *The State of the World's Children 2012: Children in an Urban World* (New York, 2012).

[6] *2011 Global Assessment Report on Disaster Risk Reduction: Revealing Risk, Redefining Development* (Geneva, 2011).

[7] Frank Thomalla and others, "Reducing hazard vulnerability: towards a common approach between disaster risk reduction and climate adaptation", *Disasters*, Vol. 30, No. 1 (March 2006).

impact and help them to cope with and recover from the effects of adversity.[8] They address issues related to health disparities that arise between the general population and the most vulnerable groups.

32. In order for the health of the population to be protected before, during and after a disaster, wider determinants of health such as security, the location of settlements, the quality of building construction, advanced hazard warnings, the availability of evacuation shelters, the level of community know-how to take action, the availability of food and water and emergency response systems need to be addressed. Essential infrastructure, such as communications, logistics, energy and water supplies, are crucial for the continuity of health services. This makes it imperative for the health sector to work with other sectors.

B. International mechanisms for humanitarian response and disaster risk reduction

Inter-agency Standing Committee

33. The international emergency response relies on the Inter-agency Standing Committee, which is composed of United Nations agencies, non-governmental organizations and the World Bank under the overall leadership of the United Nations Emergency Relief Coordinator. Building on the principles of General Assembly resolution 60/124 on strengthening of the coordination of emergency humanitarian assistance of the United Nations and subsequent lessons learned, specifically in response to the major emergencies in Haiti and Pakistan, in 2011 the United Nations humanitarian system adopted a "transformative agenda", which strengthens mechanisms to provide a collective system-wide response from all partners, focusing on leadership and coordination.

34. The importance of this reform to the health sector is to be looked at in the light of the fact that in large-scale disasters, such as those in Haiti and Pakistan in 2010, more than 300 humanitarian agencies may be registered under the health cluster, posing enormous challenges for coordination. The Global Health Cluster, which is led by WHO, gathers together more than 30 partner organizations. Its main role is to manage the response as well as to provide policy guidance and health information management, including the compilation of health data on mortality, morbidity, nutritional status and delivery of health services.

International Strategy for Disaster Reduction system

35. The health sector has a prominent role in the International Strategy for Disaster Reduction system at global, regional and national levels. The Hyogo Framework for Action 2005-2015, entitled "Building the Resilience of Nations and Communities to Disasters" (A/CONF.206/6), includes health and in particular focuses on safer hospitals as a key outcome of the Global Platforms for Disaster Risk Reduction in 2009 and 2011.

36. Within the framework of the International Strategy for Disaster Reduction, WHO has worked with partners to establish an international multidisciplinary and

[8] International Federation of Red Cross and Red Crescent Societies, Strategic Operational Framework for Health 2011-2015.

multisectoral thematic platform on disaster risk management for health. A key objective of the platform is to strengthen health sector participation in national mechanisms for disaster risk reduction, as well as in the respective global and regional forums. The platform will also harness health sector capacities and help to strengthen the collaboration between health and non-health sectors for implementation of the Hyogo Framework for Action. As it embarks on the process for determining a successor to the Framework in 2015, the foreign policy community, working with the health community and other sectors, has an important opportunity to ensure that there is an increased focus on health in future global disaster risk management systems and frameworks.

C. Strengthening national and community health emergency risk management

37. Health emergency risk management is an essential public health function which is relevant to all countries, communities, health systems and the health workforce and should be reflected in national health policies, climate change adaptation plans and multisectoral disaster risk management systems.

38. The nature of these emergencies and their impact on health have reinforced the critical need for a multisectoral, multidisciplinary and proactive approach at national level. Health system resilience and capacity for emergency risk management are critical to multisectoral disaster risk management regardless of whether the event is due to a natural hazard, an environmental incident, the threat of disease, armed conflict, or some combination of factors.

39. The outcome of the United Nations Conference on Sustainable Development has highlighted the need to take a more proactive approach to prevention and preparedness and the development of community and country capacities to provide timely and effective response and recovery. Resilient health systems, based on primary health care at community level, can reduce underlying vulnerability, protect health facilities and services and scale up the response to meet the wide-ranging health needs in the aftermath of disasters.

40. Reducing health risks and improving health outcomes in emergencies is achievable, and progress has been made at the community, national, regional and global levels. A number of countries at high risk of natural hazards, such as Bangladesh, China, Cuba, Indonesia, Mozambique, Oman, the Philippines and Turkey, have strengthened their health emergency risk management systems, but the capacity of countries is extremely variable. In 2007, a WHO global assessment found that fewer than 50 per cent of national health sectors had a budget for emergency preparedness and response. Factors affecting capacity include weak health and disaster management systems, lack of access to resources and know-how and continuing insecurity due to conflict.

41. A national "all-hazards" health emergency risk management programme could be expected to include relevant policies, legislation, financing, health sector and multisectoral coordination mechanisms, health emergency information management, risk assessment, technical guidance, response and recovery planning, safer and prepared hospitals, risk communications, research, capacity development and programme monitoring and evaluation. Such programmes support operational capacities at the community, subnational and national levels across health

disciplines which are essential for emergency risk management. These include child health, maternal and newborn health, management of communicable diseases, chemical incidents, radiation emergencies, mass casualty management, mental health and psychosocial support, mass fatality management, nutrition, sexual and reproductive health, trauma care and water, sanitation and hygiene.

Developing adaptable and resilient health-care systems

42. Health-care systems provide core capacities for health emergency risk management, but many high-risk countries have limited basic health services and infrastructure, which compounds the challenges of emergency response, while countries with well-developed systems are often much more resilient and better prepared for disasters. Thus, strengthening of health systems including health emergency risk management programmes, enables communities and countries to deal better with health risks and builds their resilience to disasters. Health-care systems need to be prepared to cope with large numbers of patients. This may require a surge capacity to mobilize and deploy staff around the country to aid affected areas. Flexibility to deliver different functions is an essential component of health-care delivery in emergencies. This may mean reducing some services in order to increase others. Business continuity plans will enable organizations to maintain continuity of health sector operations, including identifying priority services, emergency response and recovery and communicating with staff and partner organizations.

Local action and community resilience

43. Community-based actions are at the front line of protecting health in emergencies, because local knowledge of local risks addresses the actual needs of the community; local actions prevent risks at the source by avoiding exposure to local hazards; a prepared, active and well-organized community can reduce risks and the impact of emergencies, as many lives can be saved in the first hours after an emergency through community response.

44. At the community level, policies and strategies focusing on primary health care can contribute to reducing vulnerability and preparing households, communities and health systems for disasters. Local capacity can be increased through the training of community representatives and the implementation of such measures as risk assessment and contingency planning, early warning systems, safer water and sanitation and epidemic and pandemic preparedness.

45. In October 2011, a joint statement on scaling-up the community-based health workforce for emergencies was released by the Global Health Workforce Alliance, the Office of the United Nations High Commissioner for Refugees, the United Nations Children's Fund, WHO and the International Federation of Red Cross and Red Crescent Societies. It aimed to draw attention to the vital role played by the community-based health workforce (including community health workers) in emergency risk management, promoting the scaling up, training and involvement of community health workers and reinforcing the community-based health workforce.

Safe and prepared hospitals and health infrastructure

46. The need to protect the significant investment in health facilities, health workers and patients from disasters and ensure that health services can be provided

when they are most needed in emergency settings has been translated into the "safe hospitals" programmes. More than 42 countries, including Lebanon, Mexico, Nepal, Peru, the Philippines, the Republic of Moldova, the Sudan and Tajikistan, now have active programmes for safer hospitals, ensuring that new facilities for responding to disasters have been made more resilient to natural hazards and hospitals which were damaged by disasters have been rebuilt in such a way that they are safer than before. At the global level, the Hyogo Framework for Action set a goal for all new hospitals to be built with a level of protection that would better guarantee their ability to remain functional and deliver health services in crisis situations.

Support to Member States for health emergency risk management

47. The establishment of a more robust evidence base is necessary to provide support for emergency risk management programmes in countries that are at risk. This may best be achieved by a multisectoral and multidisciplinary forum promoting and coordinating the identification of operational research priorities, enhanced data-sharing and coordination and the development of multifunctional instruments to collect a minimum data set of information and ensuring that evidence and learning are used to influence decision-making at all levels of health care. Support for countries through post-disaster needs assessments is required to fully integrate health into strategies for sustainable recovery, including for transition planning between emergency response and long-term development, which incorporates the strengthening of health systems and measures to reduce the health risks of disasters in the future.

48. Ministers of health have made several high-level policy commitments on health emergency risk management at the global and regional levels. In 2011, the World Health Assembly adopted resolution WHA 64.10 on strengthening national health emergency and disaster management capacity and the resilience of health systems.

49. WHO has developed a new emergency response framework that identifies core commitments, performance standards and procedures and policies for enhancing the quality and predictability of the WHO response to both public health and humanitarian emergencies at country level and serves as a common operational platform for the work of WHO in emergencies. The full application of the emergency response framework will require further investment at the headquarters and regional levels and in countries affected by protracted and repeated emergencies, so that the necessary core staffing for the management of such a programme can be established and sustained.

50. WHO is also developing a health emergency risk management framework as a companion to the emergency response framework. It will serve as a policy document outlining the key principles and core components of a country's health emergency risk management system using an "all-hazards" approach. It will be complemented by technical guidance and assistance from WHO for the development of country capacities to manage the health risks associated with emergencies from all types of hazards.

IV. Universal health coverage

51. Climate change and natural disasters are global challenges faced by all countries. Their impact goes to the heart of societies, communities, families and individuals. The response has to be as effective and multifaceted as the challenges themselves. Joint and coordinated sets of actions across sectors are necessary to tackle the broad and diverse effects of these phenomena.

52. Human health, which is greatly affected by climate change and natural disasters, is also highly visible and easy to measure. The health sector first must mitigate the immediate and long-term persistent health effects and second must protect and sustain the gains and achievements made in the most effective way. Countries cannot afford separate and divergent approaches to each specific disease or condition.

53. Although challenges are specific to each country, political discussions and commitments at the global level can shape ways in which international collaboration and support can strengthen actions at the national level. Universal health coverage offers a path to such collaboration.

A. Path to universal coverage

54. In many countries, progress in health, especially in the areas of child and maternal mortality and the fight against major communicable diseases, such as AIDS, tuberculosis and malaria, has been impressive. These issues have benefited from the increased political attention brought about by the adoption of the Millennium Development Goals. However, current investment in health is insufficient, and, with the current resource constraints, new solutions for sustaining health gains need to be considered.

55. At the same time, new epidemiological and demographic trends have a profound impact on global health. At the national level, it is not feasible to support health systems with a limited focus on a few selected diseases or conditions. Rather, the new reality requires health systems that are accessible and efficient and that provide affordable protection against the financial risks of ill health, thus preventing the exclusion of disadvantaged members of the population and addressing vulnerabilities.

56. Universal health coverage captures the aspiration that everyone will be able to obtain the high-quality health services they need without the risk of suffering severe financial hardship when using them.[9] The goal of achieving universal health coverage has two important and interrelated components: coverage for everyone who needs health services (including prevention, promotion, treatment and rehabilitation) and coverage with financial risk protection.

57. Both components are critical to the fulfilment of the highest attainable level of health, a fundamental human right embedded in the WHO constitution of 1948 and in the Universal Declaration of Human Rights. At the same time, people value them for their own sake. They sleep securely at night knowing that the health services

[9] WHO, *World Health Report 2010. Health Systems Financing: the Path to Universal Coverage* (Geneva, 2010).

they might require are available and of good quality and that they can afford to use them.

58. Health systems oriented to universal health coverage reflect underlying social values of solidarity, social cohesion and human security. They are not concerned only with a minimum package of services, but with the endeavour to make progress on several interrelated streams: the range of services that are available to people, the proportion of the costs of those services that are covered and the proportion of the population that is covered.

B. Need for universal coverage

59. The agenda for global health is changing. In view of shifting population dynamics, notably in the areas of ageing and migration, it is important to recognize the immense societal and economic consequences of failing to address emerging issues, notably non-communicable diseases. At the same time, there is an unfinished agenda in relation to communicable diseases, reproductive and sexual health and maternal, child and newborn health.

60. Persistent financial constraints put further emphasis on the need to address global health from the viewpoint of health equity and the right to health. Meaningful universal coverage of health services requires that people have timely access to all the services they need.

61. Timely access to health services — a mix of promotion, prevention, treatment and rehabilitation — is critical to human well-being. Strong, well-designed health delivery systems protect people from illness and impoverishment by keeping them healthy. They also contribute to social harmony by providing assurances to the population that services are available in the event of illness.

62. Today, however, more than 1 billion people do not have access to the health services they need when they need them, because they are either unavailable or unaffordable.

63. Many countries still rely heavily on direct out-of-pocket payments, such as user fees, collected at the time of use, to finance their health systems. This not only prevents many of the poor and disadvantaged from seeking or continuing health care, but is also a major cause of impoverishment for many who do obtain care.

64. WHO estimates that 150 million people each year suffer severe financial hardship — called financial catastrophe — because they fall ill, use health services and need to pay for them on the spot. Many have to sell assets or go into debt to meet the payments. An additional 100 million people are pushed under the poverty line each year for this reason.

65. This results in the unacceptable paradox that the lack of access to health services impoverishes people because ill health renders them unable to work, while using health services can impoverish people, or push them deeper into poverty, because of the costs.

66. As such, universal health coverage links the social and economic pillars of sustainable development and is central to poverty reduction. People who are healthy are better able to learn, to earn and to contribute positively to the societies in which they live. Strong, affordable, well-designed health systems not only protect

individuals from illness and impoverishment but also stimulate economic growth. Universal coverage is a critical component of sustainable development.

C. Orienting systems to universal coverage

67. Moving towards universal health coverage means making progress on any or all of its components:

(a) Reducing the gap between need and use of services;

(b) Improving quality of care so that services are effective;

(c) Assuring financial risk protection so that people do not suffer financial ruin as a consequence of paying for the health services they use.

68. For many countries, universal health coverage is an objective that will need to guide the development of their health systems over many years. Others struggle to maintain the gains they have made in the past in the face of ageing populations, increasing population demands and new, generally more expensive technologies for maintaining or improving health. Universal health coverage is a goal relevant to every country.

69. One of the key policy areas relates to health system financing, where WHO has defined three broad pathways for moving towards universal health coverage. These are: (a) raising more money for health care; (b) reducing financial barriers to services and increasing financial risk protection by increasing the share of funding of the total system that is prepaid and pooled; and (c) improving efficiency and equity in the use of funds (getting "more health for the money").

70. These paths to universal health coverage are not mutually exclusive; countries can and do pursue them simultaneously. Countries also have different needs, so not all will pay the same attention to each component. In the past decade, however, countries at all income levels have taken steps to increase funding for health, reduce financial barriers to access and increase financial risk protection or improve efficiency and equity in resource use. This suggests that every country can do something more to move closer to universal health coverage or maintain the gains of the past.

71. Universal health coverage is not solely the domain of health financing; indeed, without concomitant attention to other critical aspects of health systems, little can be achieved. To ensure the appropriate health services are available, or to improve quality, for example, requires a mix of trained and motivated health-care personnel working in health-care facilities located close to people, with adequate equipment and supplies, such as medicine and diagnostic devices. The move towards universal health coverage requires a concerted effort to identify and redress obstacles to progress across the entire health system.

72. Even more broadly, factors outside the health system — the social determinants — strongly influence the ability to achieve the desired goals. Those factors, along with efforts to improve health financing and broader health systems, must be considered as being mutually supportive.

73. A focus on universal health coverage encourages a multisectoral approach and requires active consideration of broad financial considerations, economic constraints

and social determinants in addition to specific questions linked to the availability, quality and affordability of health services. It has the potential to increase economic growth, improve educational opportunities, reduce impoverishment and other inequalities and eradicate poverty.

D. Relevance to the international development agenda

74. The momentum for universal coverage is growing, not only among national Governments but in civil society and the international community, through a variety of actions, reforms and activities.

75. In its resolution 58.33, on sustainable health financing, universal coverage and social health insurance, the World Health Assembly stressed that everyone should be able to access health services and not be subject to financial hardship in doing so. The *World Health Report 2010* paved the way for intensifying efforts in defining and promoting universal health coverage as a way for countries to strengthen their health systems, maintain their achievements and sustain better health outcomes for their population.

76. It was realized early on that universal health coverage would not be achieved only by investing in health financing systems. In its resolution WHA 64.9 on sustainable health financing structures and universal coverage, the World Health Assembly urged countries to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services.

77. The aspirations behind universal health coverage have a long tradition at WHO. They have always been an intrinsic part of an integrated approach to strengthening health systems and its elements at the national level. Together with people-centred care, inclusive leadership for health and "health-in-all" policies, universal health coverage is seen as one of the four important components of primary health care. In a number of recent resolutions, the World Health Assembly has emphasized the need to develop all parts of the health system to give people access to the high-quality health services they need. Those have included resolutions on strengthening national policy dialogue to build more robust health policies, strategies and plans (WHA 64.8), the WHO Global Code of Practice on the International Recruitment of Health Personnel (WHA 63.16), strengthening the capacity of Governments to constructively engage the private sector in providing essential health-care services (WHA 63.27), strengthening of health information systems (WHA 60.27) and progress in the rational use of medicines (WHA 60.16).

78. More broadly, in its resolution WHA 62.12 on primary health care, including health system strengthening, the Assembly recognized that factors outside the health sector vitally influence the health system and its ability to improve population health, something that was also included in a separate resolution on reducing health inequities through action on the social determinants of health in the same year (WHA 62.14).

79. Universal health coverage is an essential component of the United Nations system's Social Protection Floor Initiative, which focuses on access to social

services and social protection and is key to reducing social inequality, promoting social justice and eradicating poverty.

80. In 2012, participants in a number of prominent high-level meetings have recognized the importance of universal health coverage, critical not only from a health perspective, but equally as a contributor to broader human development. In January ministers of health and other participants in a conference held in Bangkok on the theme "Moving towards universal health coverage: health financing matters" adopted the Bangkok statement on universal health coverage, and in April leaders gathered by the Government of Mexico at a forum on universal health coverage adopted a declaration entitled "Sustaining universal health coverage: sharing experiences and promoting progress". Both declarations urged countries to consider moving the debate about universal health coverage into the intersectoral environment of the United Nations, and in the Mexico declaration, participants argued that it should be included in any new or modified international development goals.

81. In the outcome document of the United Nations Conference on Sustainable Development entitled "The future we want", world leaders addressed universal health coverage by stating: "We also recognize the importance of universal health coverage to enhancing health, social cohesion and sustainable human and economic development. We pledge to strengthen health systems towards the provision of equitable universal coverage. We call for the involvement of all relevant actors for coordinated multisectoral action to address urgently the health needs of the world's population."

82. As we move into a period of reflection relating to progress since the adoption of the United Nations Millennium Declaration (see General Assembly resolution 55/2) and a possible redefinition or renewal of a set of development goals, it is important to recognize that the aim of universal health coverage — the ability of all people to use the critical health services they need without fear of the impoverishment associated with paying for them — is one of the keys to sustainable development.

V. Conclusions

83. **Building on the progress and opportunities presented above, there is a continuing need to put people and their health at the centre of global policies, legal frameworks and other collective efforts on any broad future development agenda. Against the backdrop of increasing risks and the public health consequences of emerging challenges, increased cooperation, investment and action are needed to achieve better health outcomes for all people and to make them safer and more resilient.**

84. **Leadership is critical to providing the necessary policy direction and mechanisms for consistent and predictable levels of funding for national initiatives and programmes for health and other relevant sectors. Partnerships across sectors at all levels are vital to ensuring that people are protected from the risks of ill health, irrespective of the cause.**

85. **The health sector and its partners have much of the know-how required to ensure a safer tomorrow, but political commitment at the highest level will help to provide the investment needed for better health outcomes for the millions of people facing the risk of ill health worldwide.**